

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **10115**  
**10113** **CERTIFICATE OF DEATH** Reg. Dist. No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>James Quarter</u>	LENGTH OF STAY (in this place) <u>1 year</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>James Quarter</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>_____</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>LAURA</u>	(First) (Middle) (Last) <u>ABBOTT</u>	DEATH: <u>OCT. 12 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Sept 21-1887</u>
9. AGE last birthday <u>68</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Mln. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>House hold</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>_____</u>	
11. BIRTHPLACE (State or foreign country): <u>Deal Island Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>WILLIAM DIZE</u>		14. MOTHER'S MAIDEN NAME: <u>REBECCA SADDLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT & ADDRESS: <u>Mrs Allen Webster - James Quarter</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE		(A) <u>Cerebral Thrombosis</u> <u>6 weeks.</u>	
ANTECEDENT CAUSE (B)		(B) <u>Generalized Arteriosclerosis</u> <u>years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>_____</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>_____</u>			
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION <u>_____</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>_____</u>		22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>Oct. 12 1955</u> , that I last saw the deceased alive on <u>Oct 11, 1955</u> and that death occurred at <u>6A</u> M, from the causes and on the date stated above.	
SIGNATURE <u>Everett C. Sutter</u>		ADDRESS <u>James Quarter Md.</u> DATE SIGNED <u>10-13-55</u>	
23. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10-14-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deal Island Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/22/55</u>		REGISTRAR'S SIGNATURE <u>Lela J. Whalley</u>	
24. FUNERAL DIRECTOR <u>Webster</u>		ADDRESS <u>Deal Island Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

WALLER & CO  
CONCESSIONS

BUREAU Y. S.

1955

RECEIVED

10114

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Virginia		COUNTY Accomack	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crisfield		5 days		TOWN Tangier Island		83 X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
79 McCready Hospital							
3. NAME OF DECEASED:				4. OATE (Month) (Day) (Year)			
(First) HOMER		(Middle) LEWIS		(Last) CROCKETT		OF OATH: October 2 1955	
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: January 21, 1890	
				9. AGE last birthday 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman				10B. KIND OF BUSINESS OR INDUSTRY: Seafood Industry		11. BIRTHPLACE (State or foreign country): Tangier Island, Va.	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Elisha Crockett				14. MOTHER'S MAIDEN NAME: unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No				16. SOCIAL SECURITY NO.			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: Mrs. Etta Parks Crockett--Tangier, Va.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONOITIONS OIRECTLY LEAOING TO DEATH							
443X IMMEDIATE CAUSE (A) acute dil. of heart							1 hour.
ANTECEOENT CAUSE (S) DUE TO (B) Myocarditis, chronic.							years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertensive cardio-vascular disease							years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING OEAHT.							
19A. OATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF OEAHT (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 27, 1955, to Oct. 2, 1955, that I last saw the deceased alive on Oct. 2, 1955, and that death occurred at 2:40 M, from the causes and on the date stated above.							
SIGNATURE C. Rawley				DATE SIGNED Oct. 3, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				NAME OF CEMETERY OR CREMATORY Swain Memorial Cemetery			
DATE REC'D BY LOCAL REGISTRAR Oct. 3, 1955				REGISTRAR'S SIGNATURE Barton S. Adams			
				24. FUNERAL DIRECTOR Bradshaw & Sons--Crisfield, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED

10109

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>39 Crisfield</u>		LENGTH OF STAY (in this place) <u>1948</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Sackertown Rd.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>LORETTA B. DRYDEN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>October 18 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>March 10, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Fairmount, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John S. Blake</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Ward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Blake Dryden-Sackertown Rd.-Crisfield, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>						<u>One day</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Recurrent Cerebral Emphyseopathy</u>						<u>3 years</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/23</u> , 19 <u>52</u> , to <u>10/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>55</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. N. Barr, M.D.</u>				ADDRESS <u>Crisfield, Md.</u>		DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Marion Station, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Barbara L. Adams</u>		24. FUNERAL DIRECTOR <u>Bradshaw &amp; Sons-Crisfield, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 31 1955

BUREAU V. S.



10115

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crisfield</u>		2 hours		TOWN <u>Dames Quarter</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>McCreedy Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) <u>INFANT</u> (Middle) <u>BOY</u> (Last) <u>FORD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>October 19 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>October 19, 1955</u>	9. AGE last birthday: <u>0</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>2</u> Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Crisfield, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Joseph Ford</u>				14. MOTHER'S MAIDEN NAME: <u>Lorraine Bozman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Joseph Ford--Dames Quarter, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Premature infant</u>						<u>5 1/2 - 6 mo</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Premature Separation Placenta</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 19, 1955</u> , to <u>Oct. 19, 1955</u> , that I last saw the deceased alive on <u>Oct. 19, 1955</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. K. Hawley</u>				ADDRESS <u>Crisfield, Md.</u>		DATE SIGNED <u>10/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dames Quarter Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dames Quarter, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Barbara L. Adams</u>		24. FUNERAL DIRECTOR ADDRESS <u>Leroy G. Webster-Deal Island, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 31 1965

RECEIVED

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10119  
10110 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Maryland	COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) 39 OR TOWN Crisfield	LENGTH OF STAY (in this place) 20 years	CITY (If outside corporate limits, write RURAL and give nearest town) 39 OR TOWN Crisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 N. 7th St.		STREET ADDRESS (If rural give location) 1 N. 7th St.	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) EDITH	(Middle) DENNIS	(Last) GALE	(Month) October 3 (Year) 19 55
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: June 12, 1890
9. AGE last birthday 65 yrs.		10. BIRTHPLACE (State or foreign country): Marion Station, Md.	
11. BIRTHPLACE (State or foreign country): USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Arza Dennis		14. MOTHER'S MAIDEN NAME: Mary Whittington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 217-03-0842	
17. INFORMANT & ADDRESS: Linwood Gale--N. 7th St.--Crisfield, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cerebro-Vascular Accident</u>		one day
ANTECEDENT CAUSE (B) <u>Generalized Atherosclerosis</u>		
DUE TO (C) <u>Hypertension</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		18 mo.

19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-8, 1954, to 10-3, 1955, that I last saw the deceased alive on 10-3, 1955, and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
SIGNATURE Q. N. Barr, M.D.		DATE SIGNED 10-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 6, 1955	
NAME OF CEMETERY OR CREMATORY Private Family Cemetery		LOCATION (City, town, or county) Marion Station, Md.	

DATE REC'D BY LOCAL REGISTRAR Oct 6, 1955	REGISTRAR'S SIGNATURE Barbara S. Adams	24. FUNERAL DIRECTOR Bradshaw & Sons--Crisfield, Md.	ADDRESS
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

OCT 10 1955

RECEIVED

10111

## CERTIFICATE OF DEATH

Reg. Dist. No. *255*.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Somerset</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>39</i> <i>Garfield</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>39</i> <i>Garfield</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Borcelius</i> <i>Hall</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>oct</i> <i>10</i> <i>1955</i>			
5. SEX: <i>male</i>		6. COLOR OR RACE: <i>col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>		8. DATE OF BIRTH: <i>mar 22-1881</i>	
9. AGE last birthday <i>74</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>for work rail dealer</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>accomac va</i>		12. CITIZEN OF WHAT COUNTRY: <i>u s a</i>	
13. FATHER'S NAME: <i>Handy Hall</i>				14. MOTHER'S MAIDEN NAME: <i>Georganna Waters</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>220-03-8765</i>		17. INFORMANT & ADDRESS: <i>Annie Hall Garfield Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Abdominal and Osseous Metastasis</i>						<i>1 year</i>	
ANTECEDENT CAUSE (S) DUE TO (B) <i>Carcinoma of the Prostate</i>						<i>3 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>Oct. 1952</i>				19B. MAJOR FINDINGS OF OPERATION: <i>Carcinoma of the Prostate (Philadelphia General Hospital)</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb. 2</i> , 1955, to <i>10/10</i> , 1955, that I last saw the deceased alive on <i>10-6</i> , 1955, and that death occurred at <i>5:00 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>A. N. Barr</i>				ADDRESS <i>Garfield Md.</i>		DATE SIGNED <i>10/11/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Oct 13-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Lawsonia</i>		LOCATION (City, town, or county) (State) <i>Garfield Somerset Co Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Oct 13-55</i>		REGISTRAR'S SIGNATURE <i>Bartow Adams</i>		24. FUNERAL DIRECTOR <i>Charles H. Wood</i>		ADDRESS <i>Marion St Md</i>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 17 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10121	
Item 21f Film G187 10-14-55 am				10116	
CERTIFICATE OF DEATH				Reg. Dist. No. 260	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Somerset		MARYLAND		STATE Florida COUNTY Highland	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X Crisfield		dead on arrival		Avon Park 48X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)			
99 McCready Hospital		400 Green St.			
3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First) (Middle) (Last)			OF DEATH: October 2 1955		
THOMAS HARRIS					
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
Male	Colored	Married	August 1892	63 yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
foreman		Farming		Birmingham, Alabama	
12. CITIZEN OF WHAT COUNTRY?			USA		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
unknown			unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
2 no		263-26-0154		1745 Master St. Miss Linniel Harris-- Camden, N. J.	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) 981X Pistol shot wound in chest					
ANTECEDENT CAUSE (B) See Report of Autopsy					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) William H. Coulbourn, M.D. DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		Rehoboth Somerset Md.			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? HOMICIDE	
10 2 1955-AM		A Shot in Chest with Pistol			
22. I hereby certify that I attended the deceased from <u>He was dead before</u> that I last saw the deceased					
alive on <u>He was called</u> and that death occurred at <u>11a</u> M, from the causes and on the date stated above.					
SIGNATURE		ADDRESS		DATE SIGNED	
Wm H Coulbourn		Crisfield Md		Oct 5-1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 10, 1955		Avon Park Cemetery	
				Avon Park, Florida	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
10/5/55		R. S. Johnson, M.D.		Bradshaw & Sons Funeral Home--Crisfield, Md.	

RECEIVED

OCT 6 1935

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10117

## CERTIFICATE OF DEATH

11222

Reg. Dist. No. 261

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Somerset</u>		STATE <u>Md.</u> COUNTY <u>Somerset</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Marion Station</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Marion Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Marion Station</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>George William Horsey</u>				<u>Oct. 31 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>Col.</u>	<u>Married</u>	<u>May 1, 1868</u>	<u>87 yrs.</u>	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Sea food</u>		<u>—</u>		<u>Marion Sta, Somerset Co</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Horsey</u>				<u>Mary E Banks</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No.</u>		<u>220-26-3211</u>		<u>Arzey T. Horsey Philadelphia, Pa.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>443X IMMEDIATE CAUSE (A)</b>				<u>Inanition</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Hypertensive Arteriosclerotic Cardio-Vascular</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<u>Senility</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Senility</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>0</u>		<u>—</u>		<u>5 mo</u>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<input type="checkbox"/>		<u>—</u>		<u>—</u>		<u>—</u>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>—</u>		<u>—</u>		<u>—</u>			
<b>22. I hereby certify that I attended the deceased from <u>Oct 10/22</u>, 19<u>54</u>, to <u>Oct 31</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10/22</u>, 19<u>55</u>, and that death occurred at <u>4:40</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>A. N. Bam</u>				<u>11/1/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATOR</b>		<b>LOCATION (City, town, or county)</b>	
<u>Burial</u>		<u>Nov. 3, 1955</u>		<u>Branch Liberia</u>		<u>Marion Station Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>11-9-55</u>		<u>Nellie D. Payne</u>		<u>Charles H. Ward</u>		<u>Marion Sta, Md.</u>	
<b>DATE</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>11-9-55</u>		<u>Nellie D. Payne</u>		<u>Charles H. Ward</u>		<u>Marion Sta, Md.</u>	

Box 235



1. The first step is to identify the problem. In this case, the problem is that the company is not meeting its sales targets. This could be due to a variety of factors, such as a lack of marketing, poor timing of the product launch, or a change in consumer behavior.

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **12 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10118

## CERTIFICATE OF DEATH

10122

Reg. Dist. No. 261

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u> STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Adeline</u> (Middle) <u>Lankford</u> (Last) <u>Lankford</u>		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 14, 1874</u>
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Marion Station</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Small</u>	
14. MOTHER'S MAIDEN NAME <u>Milky Henry</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS <u>Estella Whittington, Marion Sta.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 434.3 IMMEDIATE CAUSE (A) <u>Acute dilatation of heart</u>			<u>3</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Haemia &amp; Anasarca</u>			<u>1 mo</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatoid arthritis</u>			<u>15-16 years</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 29</u> , 19 <u>55</u> , to <u>Oct 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 29</u> , 19 <u>55</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>C. R. Hawley</u>		M. D. <u>Crisfield, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Nov 4 1955</u>		REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md. Box 235</u>	

10152

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

Form 100-101-101

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)  
3. Date of birth (Month, Day, Year)  
4. Place of birth (City, State, Country)

5. Marital status (Single, Married, Widowed, Divorced)  
6. Occupation (Print or write full name)

7. Cause of death (Print or write full name)  
8. Date of death (Month, Day, Year)

9. Signature of physician (Print or write full name)  
10. Signature of registrar (Print or write full name)

11. Signature of informant (Print or write full name)  
12. Signature of witness (Print or write full name)

13. Signature of funeral director (Print or write full name)  
14. Signature of undertaker (Print or write full name)

15. Signature of health officer (Print or write full name)  
16. Signature of coroner (Print or write full name)

17. Signature of medical examiner (Print or write full name)  
18. Signature of pathologist (Print or write full name)

19. Signature of physician (Print or write full name)  
20. Signature of registrar (Print or write full name)

21. Signature of informant (Print or write full name)  
22. Signature of witness (Print or write full name)

23. Signature of funeral director (Print or write full name)  
24. Signature of undertaker (Print or write full name)

25. Signature of health officer (Print or write full name)  
26. Signature of coroner (Print or write full name)

27. Signature of medical examiner (Print or write full name)  
28. Signature of pathologist (Print or write full name)

29. Signature of physician (Print or write full name)  
30. Signature of registrar (Print or write full name)

31. Signature of informant (Print or write full name)  
32. Signature of witness (Print or write full name)

33. Signature of funeral director (Print or write full name)  
34. Signature of undertaker (Print or write full name)

35. Signature of health officer (Print or write full name)  
36. Signature of coroner (Print or write full name)

37. Signature of medical examiner (Print or write full name)  
38. Signature of pathologist (Print or write full name)

39. Signature of physician (Print or write full name)  
40. Signature of registrar (Print or write full name)

41. Signature of informant (Print or write full name)  
42. Signature of witness (Print or write full name)

43. Signature of funeral director (Print or write full name)  
44. Signature of undertaker (Print or write full name)

45. Signature of health officer (Print or write full name)  
46. Signature of coroner (Print or write full name)

47. Signature of medical examiner (Print or write full name)  
48. Signature of pathologist (Print or write full name)

49. Signature of physician (Print or write full name)  
50. Signature of registrar (Print or write full name)

51. Signature of informant (Print or write full name)  
52. Signature of witness (Print or write full name)

53. Signature of funeral director (Print or write full name)  
54. Signature of undertaker (Print or write full name)

55. Signature of health officer (Print or write full name)  
56. Signature of coroner (Print or write full name)

57. Signature of medical examiner (Print or write full name)  
58. Signature of pathologist (Print or write full name)

59. Signature of physician (Print or write full name)  
60. Signature of registrar (Print or write full name)

61. Signature of informant (Print or write full name)  
62. Signature of witness (Print or write full name)

63. Signature of funeral director (Print or write full name)  
64. Signature of undertaker (Print or write full name)

65. Signature of health officer (Print or write full name)  
66. Signature of coroner (Print or write full name)

67. Signature of medical examiner (Print or write full name)  
68. Signature of pathologist (Print or write full name)

69. Signature of physician (Print or write full name)  
70. Signature of registrar (Print or write full name)

71. Signature of informant (Print or write full name)  
72. Signature of witness (Print or write full name)

73. Signature of funeral director (Print or write full name)  
74. Signature of undertaker (Print or write full name)

75. Signature of health officer (Print or write full name)  
76. Signature of coroner (Print or write full name)

77. Signature of medical examiner (Print or write full name)  
78. Signature of pathologist (Print or write full name)

79. Signature of physician (Print or write full name)  
80. Signature of registrar (Print or write full name)

81. Signature of informant (Print or write full name)  
82. Signature of witness (Print or write full name)

83. Signature of funeral director (Print or write full name)  
84. Signature of undertaker (Print or write full name)

85. Signature of health officer (Print or write full name)  
86. Signature of coroner (Print or write full name)

BUREAU V. S.

NOV 4 1952

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
100 NORTH ST. BALTIMORE, MD. 21201  
TELEPHONE 555-1234  
FAX 555-5678  
WWW.MDHEALTH.GOV

10119

## CERTIFICATE OF DEATH

Reg. Dist. No. 26.5...

1. PLACE OF DEATH: COUNTY <b>Somerset</b> MARYLAND CITY (If outside corporate limits, write RURAL) <b>Crisfield</b> OR and give nearest town TOWN <b>Crisfield</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>McCready Hospital</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Md.</b> COUNTY <b>Worcester</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Pocomoke</b> STREET ADDRESS (If rural give location) <b>RFD #3</b>	
3. NAME OF DECEASED: (Type or Print) (First) <b>G.</b> (Middle) <b>RUFUS</b> (Last) <b>MASON</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Oct 16,</b> 19 <b>55</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>March 2, 1878</b>
9. AGE last birthday <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>George L. Mason</b>		14. MOTHER'S MAIDEN NAME: <b>Margaret Ellen Dickerson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS: <b>Clara R. Mason, Pocomoke, Md.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>260X</b> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) <b>Thrombosis Acute Dil. of Heart</b> DUE TO (B) <b>Chronic myocarditis + Chronic lat. Nephritis + Diabetes mellitus</b> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct. 9, 1955</b> , to <b>Oct 16, 1955</b> , that I last saw the deceased alive on <b>Oct. 16, 1955</b> , and that death occurred at <b>3:50 P.M.</b> from the causes and on the date stated above. SIGNATURE <b>Henry C. Cadburn</b> ADDRESS <b>Marion Sta. Md.</b> DATE SIGNED <b>Oct. 18, 1955</b> M.D.			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>10/19/55</b>	
NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pocomoke, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Oct. 16, 1955</b>		REGISTRAR'S SIGNATURE <b>Nellie D. Payne</b>	
24. FUNERAL DIRECTOR <b>Henry H. Watson, Pocomoke, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 24 1955

RECEIVED



10124

MARYLAND

10120

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 360

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Princess Anne</u> LENGTH OF STAY <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Princess Anne Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Harry</u> (First) <u>H.</u> (Middle) <u>McIntire</u> (Last)		4. DATE OF DEATH <u>Oct.</u> (Month) <u>26</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Feb 14 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63</u> yrs. If under, 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James McIntire</u>		14. MOTHER'S MAIDEN NAME <u>Louise Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Dr. George Dunn</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>myocardial rupture</u>			<u>instantly</u>
Antecedent cause(s) (b) <u>Coronary occlusion</u>			<u>50 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arteriosclerotic cardiovascular disease</u>			<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-23</u> , 19 <u>53</u> to <u>10-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-21</u> , 19 <u>55</u> and that death occurred at <u>8:50</u> A.m., from the causes and on the date stated above.			
SIGNATURE <u>George M. Dunn M.D.</u> (Degree or title)		ADDRESS <u>Princess Anne Md.</u> DATE SIGNED <u>10-27-55</u>	
23. BURIAL CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE <u>10/28/55</u>		LOCATION (City, town, or county) <u>Princess Anne Md.</u>	
DATE REC'D BY LOCAL REG. <u>10/28/55</u>		24. FUNERAL DIRECTOR - ADDRESS <u>James Thomas, Princess Anne, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

NOV 21 1953

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10121

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Crisfield</b>		<b>5 days</b>		TOWN <b>Crisfield</b>		<b>39</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>McCready Hospital</b>				STREET ADDRESS (If rural give location) <b>Freemantown Rd.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>HATTIE ANNE MILES</b>				OF DEATH: <b>October 2 1955</b>			
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>Colored</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH: <b>Sept. 4, 1882</b>	
9. AGE last birthday <b>73</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Seafood Industry</b>		11. BIRTHPLACE (State or foreign country): <b>Crisfield, Md.</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>George W. Sterling</b>				14. MOTHER'S MAIDEN NAME: <b>Caroline S. Moore</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY No. <b>213-12-5257</b>		17. INFORMANT & ADDRESS: <b>Freemantown Rd. Clarence H. Sterling—Crisfield, Md.</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>							<b>5 days</b>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Viral Infection, gastric-intestinal type</b>							<b>7 days</b>
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8/22, 1955</b> , to <b>10/2, 1955</b> , that I last saw the deceased alive on <b>10/2, 1955</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>A. N. Ban</b>				ADDRESS <b>Crisfield Md</b>		DATE SIGNED <b>10/3/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Oct. 4, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Oct 4, 1955</b>		REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>		24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons—Crisfield, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED

10122

10126

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 160

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Churches Creek Rural Life</u>				TOWN <u>Rural Churches Creek, Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Shelia Elizabeth</u> (Middle) <u>Miller</u> (Last) <u>Miller</u>				(Month) <u>October</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>July 31-1955</u>	
				9. AGE last birthday: yrs. <u>2</u> Months <u>17</u> Days <u>17</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	
				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Lawrence Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Lela Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Lela Jones Kingston Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
491X Immediate cause (a) <u>Bronch - pneumonia</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. S. Johnson</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>Oct 18-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/18/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Princess Anne Cem.</u>		LOCATION (City, town, or county) (State): <u>Princess Anne, Md.</u>	
DATE REC'D BY LOCAL REG. <u>10/18/55</u>		REGISTRAR'S SIGNATURE: <u>R. S. Johnson, M.D.</u>		24. FUNERAL DIRECTOR: <u>William H. Jones, Jr.</u>		ADDRESS: <u>Princess Anne, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10123  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 260

10127  
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Rural Promoke</u>				TOWN <u>Promoke R.F.D.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		<u>Lottie</u>		<u>Mobley</u>			
4. DATE OF DEATH		(Month)		(Day)		(Year)	
		<u>Oct</u>		<u>29</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>W</u>	<u>Single</u>	<u>April 24 - 1907</u>	<u>48</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Farm</u>		<u>North Carolina USA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Mobley</u>				<u>Cherie ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>-</u>		<u>Elsie Manuel Promoke md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p>812X Immediate cause</p> <p>(a) <u>Fractured knee, Broken neck.</u></p> <p>DUE TO</p> <p>Antecedent cause(s)</p> <p>(b) <u>Internal injury - Long-purulent fracture</u></p> <p>Diseases or conditions, if any, giving rise to the above cause</p> <p>DUE TO</p> <p>(c) <u>Right and left legs -</u></p> <p>stating underlying cause last</p>						<u>None</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
		<u>Wood</u>		<u>Promoke city Somerset Maryland</u>		<u>19</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>Oct 29-55 7:30 P.M.</u>				<u>ran in front of car on Highway 13 -</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
<u>R. Johnson</u>				<u>Oct 31-55</u>			
M. D. ASSISTANT MEDICAL EXAM.							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-2-55</u>		<u>Wharton Memorial Cemetery</u>		<u>Parksley, Virginia</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11/3/55</u>		<u>R. Johnson, M.D.</u>		<u>Wharton &amp; Savage Funeral Home-New Church,</u>		<u>Virginia</u>	

DEATH RECORD

THIS FORM IS TO BE FILLED OUT BY THE DEATH RECORDER, AND IS TO BE KEPT IN THE DEATH RECORD BOOK, AND IS NOT TO BE DESTROYED UNTIL THE DEATH RECORDER HAS BEEN ADVISED BY THE HEALTH DEPARTMENT THAT IT MAY BE DESTROYED.

1. NAME OF DECEASED (Type in full)		2. SEX (Type in full)		3. AGE (Type in full)		4. PLACE OF BIRTH (Type in full)	
5. DATE OF DEATH (Type in full)		6. TIME OF DEATH (Type in full)		7. PLACE OF DEATH (Type in full)		8. PLACE OF BIRTH (Type in full)	
9. NAME OF DECEASED (Type in full)		10. SEX (Type in full)		11. AGE (Type in full)		12. PLACE OF BIRTH (Type in full)	
13. DATE OF DEATH (Type in full)		14. TIME OF DEATH (Type in full)		15. PLACE OF DEATH (Type in full)		16. PLACE OF BIRTH (Type in full)	
17. NAME OF DECEASED (Type in full)		18. SEX (Type in full)		19. AGE (Type in full)		20. PLACE OF BIRTH (Type in full)	
21. DATE OF DEATH (Type in full)		22. TIME OF DEATH (Type in full)		23. PLACE OF DEATH (Type in full)		24. PLACE OF BIRTH (Type in full)	
25. NAME OF DECEASED (Type in full)		26. SEX (Type in full)		27. AGE (Type in full)		28. PLACE OF BIRTH (Type in full)	
29. DATE OF DEATH (Type in full)		30. TIME OF DEATH (Type in full)		31. PLACE OF DEATH (Type in full)		32. PLACE OF BIRTH (Type in full)	
33. NAME OF DECEASED (Type in full)		34. SEX (Type in full)		35. AGE (Type in full)		36. PLACE OF BIRTH (Type in full)	
37. DATE OF DEATH (Type in full)		38. TIME OF DEATH (Type in full)		39. PLACE OF DEATH (Type in full)		40. PLACE OF BIRTH (Type in full)	
41. NAME OF DECEASED (Type in full)		42. SEX (Type in full)		43. AGE (Type in full)		44. PLACE OF BIRTH (Type in full)	
45. DATE OF DEATH (Type in full)		46. TIME OF DEATH (Type in full)		47. PLACE OF DEATH (Type in full)		48. PLACE OF BIRTH (Type in full)	
49. NAME OF DECEASED (Type in full)		50. SEX (Type in full)		51. AGE (Type in full)		52. PLACE OF BIRTH (Type in full)	
53. DATE OF DEATH (Type in full)		54. TIME OF DEATH (Type in full)		55. PLACE OF DEATH (Type in full)		56. PLACE OF BIRTH (Type in full)	
57. NAME OF DECEASED (Type in full)		58. SEX (Type in full)		59. AGE (Type in full)		60. PLACE OF BIRTH (Type in full)	
61. DATE OF DEATH (Type in full)		62. TIME OF DEATH (Type in full)		63. PLACE OF DEATH (Type in full)		64. PLACE OF BIRTH (Type in full)	
65. NAME OF DECEASED (Type in full)		66. SEX (Type in full)		67. AGE (Type in full)		68. PLACE OF BIRTH (Type in full)	
69. DATE OF DEATH (Type in full)		70. TIME OF DEATH (Type in full)		71. PLACE OF DEATH (Type in full)		72. PLACE OF BIRTH (Type in full)	
73. NAME OF DECEASED (Type in full)		74. SEX (Type in full)		75. AGE (Type in full)		76. PLACE OF BIRTH (Type in full)	
77. DATE OF DEATH (Type in full)		78. TIME OF DEATH (Type in full)		79. PLACE OF DEATH (Type in full)		80. PLACE OF BIRTH (Type in full)	
81. NAME OF DECEASED (Type in full)		82. SEX (Type in full)		83. AGE (Type in full)		84. PLACE OF BIRTH (Type in full)	
85. DATE OF DEATH (Type in full)		86. TIME OF DEATH (Type in full)		87. PLACE OF DEATH (Type in full)		88. PLACE OF BIRTH (Type in full)	
89. NAME OF DECEASED (Type in full)		90. SEX (Type in full)		91. AGE (Type in full)		92. PLACE OF BIRTH (Type in full)	
93. DATE OF DEATH (Type in full)		94. TIME OF DEATH (Type in full)		95. PLACE OF DEATH (Type in full)		96. PLACE OF BIRTH (Type in full)	
97. NAME OF DECEASED (Type in full)		98. SEX (Type in full)		99. AGE (Type in full)		100. PLACE OF BIRTH (Type in full)	
101. DATE OF DEATH (Type in full)		102. TIME OF DEATH (Type in full)		103. PLACE OF DEATH (Type in full)		104. PLACE OF BIRTH (Type in full)	
105. NAME OF DECEASED (Type in full)		106. SEX (Type in full)		107. AGE (Type in full)		108. PLACE OF BIRTH (Type in full)	
109. DATE OF DEATH (Type in full)		110. TIME OF DEATH (Type in full)		111. PLACE OF DEATH (Type in full)		112. PLACE OF BIRTH (Type in full)	
113. NAME OF DECEASED (Type in full)		114. SEX (Type in full)		115. AGE (Type in full)		116. PLACE OF BIRTH (Type in full)	
117. DATE OF DEATH (Type in full)		118. TIME OF DEATH (Type in full)		119. PLACE OF DEATH (Type in full)		120. PLACE OF BIRTH (Type in full)	
121. NAME OF DECEASED (Type in full)		122. SEX (Type in full)		123. AGE (Type in full)		124. PLACE OF BIRTH (Type in full)	
125. DATE OF DEATH (Type in full)		126. TIME OF DEATH (Type in full)		127. PLACE OF DEATH (Type in full)		128. PLACE OF BIRTH (Type in full)	
129. NAME OF DECEASED (Type in full)		130. SEX (Type in full)		131. AGE (Type in full)		132. PLACE OF BIRTH (Type in full)	
133. DATE OF DEATH (Type in full)		134. TIME OF DEATH (Type in full)		135. PLACE OF DEATH (Type in full)		136. PLACE OF BIRTH (Type in full)	
137. NAME OF DECEASED (Type in full)		138. SEX (Type in full)		139. AGE (Type in full)		140. PLACE OF BIRTH (Type in full)	
141. DATE OF DEATH (Type in full)		142. TIME OF DEATH (Type in full)		143. PLACE OF DEATH (Type in full)		144. PLACE OF BIRTH (Type in full)	
145. NAME OF DECEASED (Type in full)		146. SEX (Type in full)		147. AGE (Type in full)		148. PLACE OF BIRTH (Type in full)	
149. DATE OF DEATH (Type in full)		150. TIME OF DEATH (Type in full)		151. PLACE OF DEATH (Type in full)		152. PLACE OF BIRTH (Type in full)	
153. NAME OF DECEASED (Type in full)		154. SEX (Type in full)		155. AGE (Type in full)		156. PLACE OF BIRTH (Type in full)	
157. DATE OF DEATH (Type in full)		158. TIME OF DEATH (Type in full)		159. PLACE OF DEATH (Type in full)		160. PLACE OF BIRTH (Type in full)	
161. NAME OF DECEASED (Type in full)		162. SEX (Type in full)		163. AGE (Type in full)		164. PLACE OF BIRTH (Type in full)	
165. DATE OF DEATH (Type in full)		166. TIME OF DEATH (Type in full)		167. PLACE OF DEATH (Type in full)		168. PLACE OF BIRTH (Type in full)	
169. NAME OF DECEASED (Type in full)		170. SEX (Type in full)		171. AGE (Type in full)		172. PLACE OF BIRTH (Type in full)	
173. DATE OF DEATH (Type in full)		174. TIME OF DEATH (Type in full)		175. PLACE OF DEATH (Type in full)		176. PLACE OF BIRTH (Type in full)	
177. NAME OF DECEASED (Type in full)		178. SEX (Type in full)		179. AGE (Type in full)		180. PLACE OF BIRTH (Type in full)	
181. DATE OF DEATH (Type in full)		182. TIME OF DEATH (Type in full)		183. PLACE OF DEATH (Type in full)		184. PLACE OF BIRTH (Type in full)	
185. NAME OF DECEASED (Type in full)		186. SEX (Type in full)		187. AGE (Type in full)		188. PLACE OF BIRTH (Type in full)	
189. DATE OF DEATH (Type in full)		190. TIME OF DEATH (Type in full)		191. PLACE OF DEATH (Type in full)		192. PLACE OF BIRTH (Type in full)	
193. NAME OF DECEASED (Type in full)		194. SEX (Type in full)		195. AGE (Type in full)		196. PLACE OF BIRTH (Type in full)	
197. DATE OF DEATH (Type in full)		198. TIME OF DEATH (Type in full)		199. PLACE OF DEATH (Type in full)		200. PLACE OF BIRTH (Type in full)	

BUREAU V. 2

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12. I hereby certify that I took charge of the remains described above, and an autopsy was performed on the body of the deceased, and the results of the examination are as follows: (Type in full)

13. I hereby certify that I took charge of the remains described above, and an autopsy was performed on the body of the deceased, and the results of the examination are as follows: (Type in full)



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

10124

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN		<u>about 4 days</u>		TOWN <u>Farmwood</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>799 Crisfield Hospital</u>				<u>1</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH			
<u>Charles W. Richards</u>				<u>Oct 31 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>white</u>	<u>Married</u>	<u>Mar 4, 1877</u>	<u>78</u> yrs.	<u>7</u> Months	<u>—</u> Days	<u>—</u> Hours <u>—</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Malman</u>		<u>Retired Malman</u>		<u>USA</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George W. Richards</u>				<u>Mary W. Ford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:	
<u>no</u>				<u>✓</u>		<u>Mr. Blanche Ford</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE						<u>3 days</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Uremia - Cerebral Hemorrhage</u>							
DUE TO							
(B) <u>Chronic Int. Nephritis Chronic Myocarditis</u>						<u>Years</u>	
DUE TO							
(C) <u>General Arteriosclerosis &amp; Epilepsy</u>						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 28, 1955</u> , to <u>Oct 31, 1955</u> , that I last saw the deceased alive on <u>Oct 31, 1955</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>George C. Boulton</u>				<u>Indian Sta. Ind.</u>		<u>11-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 2nd</u>		<u>hof P. Cemetery</u>		<u>Upper Fairmount, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Nov. 1-1955</u>		<u>Nellie D. Payne</u>		<u>Harry B. Miles</u>		<u>Upper Fairmount Md</u>	



BUREAU V. S.

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10-25

## CERTIFICATE OF DEATH

Reg. Dist. No. 265-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		LENGTH OF STAY (in this place) 3 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Marion Station	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		McCreedy Hospital		STREET ADDRESS		(If rural give location) Quindocqua Section	
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) LUCY		(Middle) BELLE		(Last) TAYLOR		DATE OF DEATH: October 13 19 55	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: August 7, 1876	
9. AGE last birthday: 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		11. BIRTHPLACE (State or foreign country): Fairmount, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Dize				14. MOTHER'S MAIDEN NAME: Sarah Adams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no				16. SOCIAL SECURITY No. none		17. INFORMANT & ADDRESS: R.F.D. Quindocqua Mrs. Lillian Dorsey- Marion Station, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage - Thrombosis						4 yrs	
ANTECEDENT CAUSE (B) General Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Chronic Int. Nephritis & Chronic Myocarditis						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 10				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-25, 1955, to Oct. 13, 1955, that I last saw the deceased alive on Oct. 13, 1955, and that death occurred at 5:00 A. M. from the causes and on the date stated above.							
SIGNATURE Henry B. Boulton				ADDRESS Marion Sta. Md.		DATE SIGNED Oct. 14, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Oct. 15, 1955		NAME OF CEMETERY OR CREMATORY Fairmount Cemetery	
LOCATION (City, town, or county) Fairmount, Md.							
24. FUNERAL DIRECTOR				ADDRESS			
DATE REC'D BY LOCAL REGISTRAR Oct. 14, 1955				REGISTRAR'S SIGNATURE Nellie D. Payne			
24. FUNERAL DIRECTOR Bradshaw & Sons--Crisfield, Md.							

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMMUNICATIONS SECTION

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NOV 10 1955

*[Handwritten signature]*

BUREAU V. S.

OCT 24 1955

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## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>39</b>		TOWN <b>Crisfield</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>39</b>		TOWN <b>Crisfield</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		<b>Laird Ave.</b>		STREET ADDRESS (If rural give location) <b>1</b>		<b>Laird Ave.</b>	
3. NAME OF DECEASED: (First) <b>ISIAIAH</b> (Middle) (Last) <b>THOMAS</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>October 6 1955</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>		8. DATE OF BIRTH: <b>Aug. 29, 1863</b>	
9. AGE last birthday: <b>92</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Seafood Industry</b>	
11. BIRTHPLACE (State or foreign country): <b>Tangier Island, Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME: <b>Lybrand Thomas</b>				14. MOTHER'S MAIDEN NAME: <b>Polly Crockett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS:							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Nephritis</b>							
ANTECEDENT CAUSE (B) <b>Generalized Arteriosclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Benign Prostatic Hypertrophy</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Senile Degeneration</b>							
19a. DATE OF OPERATION: <b>0</b>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <b>9-23</b> , 19 <b>55</b> , to <b>10-6</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>10-5</b> , 19 <b>55</b> , and that death occurred at <b>1:20aM</b> , from the causes and on the date stated above.							
SIGNATURE <b>A. N. Ban, M.D.</b>				DATE SIGNED <b>10/6/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				DATE THEREOF <b>Oct. 9, 1955</b>			
NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>				LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>			
DATE REC'D BY LOCAL REGISTRAR <b>Oct. 7, 1955</b>				REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>			
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons—Crisfield, Md.</b>				ADDRESS			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

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